That the Senate passed without amendment H.R. 5883.

With best wishes, I am,

Sincerely,

KAREN L. HAAS.

COMMUNICATION FROM THE CLERK OF THE HOUSE

The SPEAKER pro tempore laid before the House the following communication from the Clerk of the House of Representatives:

OFFICE OF THE CLERK,
HOUSE OF REPRESENTATIVES,
Washington, DC, September 29, 2016.

Hon. PAUL D. RYAN,
The Speaker, House of Representatives, Washington, DC.

DEAR MR. SPEAKER: Pursuant to the permission granted in Clause 2(h) of Rule II of the Rules of the U.S. House of Representatives, the Clerk received the following message from the Secretary of the Senate on September 29, 2016 at 3:45 p.m.:

That the Senate agreed to with an amendment H. Con. Res. 122.

That the Senate agreed to without amendment H. Con. Res. 166.

That the Senate passed without amendment H.R. 5944.

That the Senate passed without amendment H.R. 5946.

That the Senate passed without amendment H.R. 2733.

That the Senate concur in the House of Representatives Amendment to the bill S. 246.

That the Senate passed S. 2959.

That the Senate agreed to S. Con. Res. 55.

That the Senate passed S. 2360.

With best wishes, I am,

Sincerely,

KAREN L. HAAS.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 4 of rule I, the following enrolled bill was signed by the Speaker on Wednesday, September 28, 2016:

H.R. 5325, making continuing appropriations for fiscal year 2017, and for other purposes.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 4 of rule I, the following enrolled bills were signed by the Speaker on Thursday, September 29, 2016:

H.R. 2733, to require the Secretary of the Interior to take land into trust for certain Indian tribes, and for other purposes;

H.R. 3004, to amend the Gullah/Geechee Cultural Heritage Act to extend the authorization for the Gullah/Geechee Cultural Heritage Corridor Commission;

H.R. 3937, to designate the building utilized as a United States courthouse located at 150 Reade Circle in Greenville, North Carolina, as the ''Randy D. Doub United States Courthouse'';

H.R. 5147, to amend title 40, United States Code, to require restrooms in public buildings to be equipped with baby changing facilities;

H.R. 5578, to establish certain rights for sexual assault survivors, and for other purposes;

H.R. 5883, to amend the Packers and Stockyards Act, 1921, to clarify the duties relating to services furnished in connection with the buying or selling of livestock in commerce through online, video, or other electronic methods, and for other purposes;

H.R. 5944, to amend title 49, United States Code, with respect to certain grant assurances, and for other purposes;

H.R. 5946, to amend the Internal Revenue Code of 1986 to exclude from gross income any prizes or awards won in competition in the Olympic Games or the Paralympic Games;

S. 246, to establish the Alyce Spotted Bear and Walter Soboleff Commission on Native Children, and for other purposes;

S. 3283, to designate the community-based outpatient clinic of the Department of Veterans Affairs in Pueblo, Colorado, as the ''PFC James Dunn VA Clinic''.

□ 1415

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Record votes on postponed questions will be taken later.

NATIONAL CLINICAL CARE COMMISSION ACT

Mr. BURGESS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1192) to amend the Public Health Service Act to foster more effective implementation and coordination of clinical care for people with pre-diabetes, diabetes, and the chronic diseases and conditions that result from diabetes, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1192

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''National Clinical Care Commission Act''.

SEC. 2. ESTABLISHMENT OF THE NATIONAL CLINICAL CARE COMMISSION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following new section:

''SEC. 399V–7. NATIONAL CLINICAL CARE COMMISSION.

''(a) ESTABLISHMENT.—There is hereby established, within the Department of Health and Human Services, a National Clinical Care Commission (in this section referred to as the 'Commission') to evaluate, and recommend solutions regarding better coordination and leveraging of, programs within the Department and other Federal agencies that relate in any way to supporting appropriate clinical care (such as any interactions between physicians and other health care providers and their patients related to treatment and care management) for individuals with—

''(1) a complex metabolic or autoimmune disease;

''(2) a disease resulting from insulin deficiency or insulin resistance; or

''(3) complications caused by any such disease.

''(b) MEMBERSHIP.—

''(1) IN GENERAL.—The Commission shall be composed of the following voting members:

''(A) The heads (or their designees) of the following Federal agencies and departments:

''(i) The Centers for Medicare & Medicaid Services.

''(ii) The Agency for Healthcare Research and Quality.

''(iii) The Centers for Disease Control and Prevention.

''(iv) The Indian Health Service.

''(v) The Department of Veterans Affairs.

''(vi) The National Institutes of Health.

''(vii) The Food and Drug Administration.

''(viii) The Health Resources and Services Administration.

''(ix) The Department of Defense.

''(B) Twelve additional voting members appointed under paragraph (2).

''(C) Such additional voting members as may be appointed by the Secretary, at the Secretary's discretion, from among the heads (or their designees) of governmental or nongovernmental entities that impact clinical care of individuals with any of the diseases and complications described in subsection (a).

''(2) ADDITIONAL MEMBERS.—The Commission shall include additional voting members appointed by the Secretary, in consultation with national medical societies and patient advocacy organizations with expertise in the care and epidemiology of any of the diseases and complications described in subsection (a), including one or more such members from each of the following categories:

''(A) Clinical endocrinologists.

''(B) Physician specialties (other than as described in subparagraph (A)) that play a role in diseases and complications described in subsection (a), such as cardiologists, nephrologists, and eye care professionals.

''(C) Primary care physicians.

''(D) Non-physician health care professionals, such as certified diabetes educators, registered dieticians and nutrition professionals, nurses, nurse practitioners, and physician assistants.

''(E) Patient advocates.

''(F) National experts in the duties listed under subsection (c).

''(G) Health care providers furnishing services to a patient population that consists of a high percentage (as specified by the Secretary) of individuals who are enrolled in a State plan under title XIX of the Social Security Act or who are not covered under a health plan or health insurance coverage.

''(3) CHAIRPERSON.—The voting members of the Commission shall select a chairperson from the members appointed under paragraph (2) from the category under paragraph (2)(A).

''(4) MEETINGS.—The Commission shall meet at least twice, and not more than 4 times, a year.

''(5) BOARD TERMS.—Members of the Commission appointed pursuant to subparagraph (B) or (C) of paragraph (1), including the chairperson, shall serve for a 3-year term. A vacancy on the Commission shall be filled in the same manner as the original appointments.

''(c) DUTIES.—The Commission shall—

''(1) evaluate programs of the Department of Health and Human Services regarding the utilization of diabetes screening benefits, annual wellness visits, and other preventive health benefits that may reduce the incidence of the diseases and complications described in subsection

(a), including explaining problems regarding such utilization and related data collection mechanisms;

''(2) identify current activities and critical gaps in Federal efforts to support clinicians in providing integrated, high-quality care to individuals with any of the diseases and complications described in subsection (a);

''(3) make recommendations regarding the coordination of clinically-based activities that are being supported by the Federal Government with respect to the diseases and complications described in subsection (a);

''(4) make recommendations regarding the development and coordination of federally funded clinical practice support tools for physicians and other health care professionals in caring for and managing the care of individuals with any of the diseases and complications described in subsection (a), specifically with regard to implementation of new treatments and technologies;

''(5) evaluate programs described in subsection (a) that are in existence as of the date of the enactment of this section and determine if such programs are meeting the needs identified in paragraph (2) and, if such programs are determined as not meeting such needs, recommend programs that would be more appropriate;

''(6) recommend, with respect to the diseases and complications described in subsection (a), clinical pathways for new technologies and treatments, including future data collection activities, that may be developed and then used to evaluate—

''(A) various care models and methods; and

''(B) the impact of such models and methods on quality of care as measured by appropriate care parameters (such as A1C, blood pressure, and cholesterol levels);

''(7) evaluate and expand education and awareness activities provided to physicians and other health care professionals regarding clinical practices for the prevention of the diseases and complications described in subsection (a);

''(8) review and recommend appropriate methods for outreach and dissemination of educational resources that—

''(A) regard the diseases and complications described in subsection (a);

''(B) are funded by the Federal Government; and

''(C) are intended for health care professionals and the public; and

''(9) carry out other activities, such as activities relating to the areas of public health and nutrition, that the Commission deems appropriate with respect to the diseases and complications described in subsection (a).

''(d) OPERATING PLAN.—

''(1) INITIAL PLAN.—Not later than 90 days after its first meeting, the Commission shall submit to the Secretary and the Congress an operating plan for carrying out the activities of the Commission as described in subsection (c). Such operating plan may include—

''(A) a list of specific activities that the Commission plans to conduct for purposes of carrying out the duties described in each of the paragraphs in subsection (c);

''(B) a plan for completing the activities;

''(C) a list of members of the Commission and other individuals who are not members of the Commission who will need to be involved to conduct such activities;

''(D) an explanation of Federal agency involvement and coordination needed to conduct such activities;

''(E) a budget for conducting such activities;

''(F) a plan for evaluating the value and potential impact of the Commission's work and recommendations, including the possible continuation of the Commission for the purposes of overseeing their implementation; and

''(G) other information that the Commission deems appropriate.

''(2) UPDATES.—The Commission shall periodically update the operating plan under paragraph (1) and submit such updates to the Secretary and the Congress.

''(e) FINAL REPORT.—By not later than 3 years after the date of the Commission's first meeting, the Commission shall submit to the Secretary and the Congress a final report containing all of the findings and recommendations required by this section. Not later than 120 days after the submission of the final report, the Secretary shall review the plan required by subsection (d)(1)(F) and submit to the Congress a recommendation on whether the Commission should be reauthorized to operate after fiscal year 2019.

''(f) SUNSET.—The Commission shall terminate at the end of fiscal year 2019.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. BURGESS) and the gentlewoman from Illinois (Ms. SCHAKOWSKY) each will control 20 minutes.

The Chair recognizes the gentleman from Texas.

GENERAL LEAVE

Mr. BURGESS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous materials into the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BURGESS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I rise today in support of H.R. 1192, the National Clinical Care Commission Act, introduced by my friend and colleague from Texas, Representative PETE OLSON. It has been supported by 229 cosponsors.

H.R. 1192 establishes a clinical care commission to evaluate and recommend solutions regarding better coordinating and leveraging Federal programs that relate to complex metabolic or autoimmune disorders, such as diabetes. Metabolic disorders take a large toll on many Americans each year, and complications from these disorders can lead to catastrophic health outcomes.

Currently, there are various programs across the Federal Government that touch on metabolic disorders, some focusing on prevention, others focusing on treatment, but they lack coordination. Improving coordination of such efforts provides an opportunity to reduce costs while improving health outcomes.

This legislation received broad support from the Energy and Commerce Committee, passing through a full committee markup by voice vote. H.R. 1192 provides for no new spending by utilizing only existing funds at the Department of Health and Human Services.

Mr. Speaker, I urge my colleagues to support this legislation.

I reserve the balance of my time.

Ms. SCHAKOWSKY. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I want to thank the sponsors of the bill, Congressman OLSON and Congressman LOEBSACK, for introducing this legislation. I am very proud to be one of the many cosponsors of the bill.

H.R. 1192 would help to improve Federal efforts to treat and prevent metabolic disorders, autoimmune diseases, and diseases resulting from insulin deficiency or insulin resistance.

The most common metabolic disorder in the United States, of course, is diabetes, which affects more than 29 million Americans. Another 86 million Americans have prediabetes, a condition associated with an increased risk of developing type 2 diabetes and heart disease.

Unfortunately, all too often, diabetes leads, as my colleague said, to avoidable complications such as blindness, limb amputation, and kidney failure, and it costs our healthcare system an avoidable billions of dollars each year. That is why it is important to improve Federal efforts to prevent avoidable cases of these conditions and to ensure that Americans have the treatment and management services necessary to successfully manage them.

I am pleased that we were able to work together to pass this legislation. I urge all of my colleagues to vote ''yes'' on H.R. 1192.

Mr. Speaker, I reserve the balance of my time.

Mr. BURGESS. Mr. Speaker, I yield 5 minutes to the gentleman from Texas (Mr. OLSON), the author of the bill.

Mr. OLSON. Mr. Speaker, I thank my friend from Texas.

Mr. Speaker, I rise today in support of my bill, H.R. 1192, the National Clinical Care Commission Act, a bipartisan bill which is cosponsored by over half of my House colleagues. It has this level of support because this Nation faces an epidemic. Diabetes or prediabetes affects over 100 million Americans. Nearly one in three of our neighbors are affected. Dr. Phil has diabetes. We met, and he is a strong proponent of this bill. This is in addition to all of the other Americans who have diseases that fall under complex metabolic, autoimmune, or insulin resistant diseases.

When I first came to Congress in 2009, it was crystal clear that we had a big problem. The benefits of all the Federal research dollars going into these diseases were simply not making their way to patients. The researchers at the NIH, the CDC, and even the EPA weren't sharing diabetes research. It was clear to me in 2009, and it is clear to me in 2016. We need a laser-like focus on improving patient care by pursuing a strong Federal focus on research.

My bill accomplishes that goal through the establishment of a national clinical care commission made up of doctors with specialties, such as endocrinologists, and other healthcare providers who work directly with patients and pharmacists.

This commission will have 3 years to strengthen the partnership between Federal stakeholders and health professionals who will bring hands-on, clinical experience to improve care.

This is not a new, unending bureaucracy. After 3 years, this commission will sunset. In 3 years, it will be gone.

We have made a huge investment of taxpayer dollars in research. It is time for us to leverage that investment and translate that into meaningful prevention and effective treatment options.

So today, on World Diabetes Day, I ask my colleagues to vote for H.R. 1192 and help all those who suffer from diabetes and other complex metabolic and autoimmune disorders.

Ms. SCHAKOWSKY. Mr. Speaker, the truth is, in this country, if we were able to actually get some control of diabetes—which, as the author of this bill said, affects over 100 million Americans—prediabetes or diabetes, we would be able to really get control of all healthcare costs. It is one of the biggest drivers of healthcare costs in our country.

So while this is a commission—and let's hope that the commission does its good work—we have to stay focused, as he said, on the issue of diabetes.

Mr. Speaker, I reserve the balance of my time.

Mr. BURGESS. Mr. Speaker, I yield 3 minutes to the gentleman from Georgia (Mr. CARTER), who is in support of the bill.

Mr. CARTER of Georgia. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of H.R. 1192, the National Clinical Care Commission Act, which establishes within the Department of Health and Human Services the National Diabetes Clinical Care Commission.

The commission will look into the dissemination of information and resources to clinicians on best practices for delivering high quality care and how best to effectively deploy new and emerging treatment and technologies.

As a pharmacist, I played an important role in diabetes care by screening patients who had a high risk for diabetes and educated patients to empower them to take better care of themselves.

I believe all of my colleagues would agree that making government work to help evaluate and recommend solutions regarding diabetes is important. The American Diabetes Association reports that there are almost 30 million people living with this disease.

With better coordination and leveraging of Federal programs that relate to clinical care for people with prediabetes, diabetes, and the chronic diseases and conditions caused by diabetes, we will begin to stem the tide of this awful disease.

Mr. Speaker, this legislation should be a priority for our country, and I urge my colleagues to support this bill.

Ms. SCHAKOWSKY. Mr. Speaker, I yield back the balance of my time.

Mr. BURGESS. Mr. Speaker, this is an important bill that we are acting on today. I would remind the body that it passed on a strong vote through the full committee on a voice vote, and there are many things to recommend this bill. I urge an ''aye'' vote.

Mr. Speaker, I yield back the balance of my time.

Ms. DEGETTE. Mr. Speaker, I rise today to commemorate World Diabetes Day and to urge the passage of the National Diabetes Clinical Care Commission Act (H.R. 1192), which would authorize a committee of experts to improve care for people with diabetes and associated conditions. I'd like to thank the original co-sponsors of the bill, Mr. OLSON and Mr. LOEBSACK, as well as Chairman UPTON and Ranking Member PALLONE, for all your hard work in making sure this important legislation gets the attention it deserves.

World Diabetes Day helps raise awareness of the scope of this disease. In that spirit, I'd like to note for all our colleagues that the human and economic impact of diabetes in the United States is mammoth. More than 29 million people in the United States from all walks of life have diabetes. The Centers for Disease Control estimates as many as 86 million Americans have pre-diabetes.

This disease is a life-long reality that patients and their families must grapple with every day. As the mother of a child with type 1 diabetes, I know the toll it can take. But I'm also in awe of the bravery and strength exhibited by people who live with diabetes. For them, we must continue to support innovative and thoughtful solutions that address awareness, prevention and cures.

For health care problems of this magnitude, coordination is essential. Increased communication and planning between the many different federal agencies working to prevent and treat diabetes will make a difference for patients and help us spend taxpayer dollars in a more cost-effective way. The National Clinical Care Commission Act would help jump-start these efforts by facilitating dialogue and coordination between leaders in the federal government and experts from the field. The Commission would be tasked with reviewing the many different ways the government currently spends money on diabetes and coming up with a strategic plan on how to move forward effectively and efficiently.

I have no doubt that the House will pass H.R. 1192 today. I encourage the Senate to vote on this commonsense bill as soon as possible. Thank you.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Texas (Mr. BURGESS) that the House suspend the rules and pass the bill, H.R. 1192, as amended.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

The title of the bill was amended so as to read: ''A bill to amend the Public Health Service Act to foster more effective implementation and coordination of clinical care for people with a complex metabolic or autoimmune disease, a disease resulting from insulin deficiency or insulin resistance, or complications caused by such a disease, and for other purposes.''.

A motion to reconsider was laid on the table.

IMPROVING ACCESS TO MATERNITY CARE ACT

Mr. BURGESS. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 1209) to amend the Public Health Service Act to provide for the designation of maternity care health professional shortage areas, as amended.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 1209

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Improving Access to Maternity Care Act''.

SEC. 2. MATERNITY CARE HEALTH PROFESSIONAL TARGET AREAS.

Section 332 of the Public Health Service Act (42 U.S.C. 254e) is amended by adding at the end the following new subsection:

''(k)(1) The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall identify, based on the data collected under paragraph (3), maternity care health professional target areas that satisfy the criteria described in paragraph (2) for purposes of, in connection with receipt of assistance under this title, assigning to such identified areas maternity care health professionals who, without application of this subsection, would otherwise be eligible for such assistance. The Secretary shall distribute maternity care health professionals within health professional shortage areas using the maternity care health professional target areas so identified.

''(2) For purposes of paragraph (1), the Secretary shall establish criteria for maternity care health professional target areas that identify geographic areas within health professional shortage areas that have a shortage of maternity care health professionals.

''(3) For purposes of this subsection, the Secretary shall collect and publish in the Federal Register data comparing the availability and need of maternity care health services in health professional shortage areas and in areas within such health professional shortage areas.

''(4) In carrying out paragraph (1), the Secretary shall seek input from relevant provider organizations, including medical societies, organizations representing medical facilities, and other organizations with expertise in maternity care.

''(5) For purposes of this subsection, the term 'full scope maternity care health services' includes during labor care, birthing, prenatal care, and postpartum care.

''(6) Nothing in this subsection shall be construed as—

''(A) requiring the identification of a maternity care health professional target area in an area not otherwise already designated as a health professional shortage area; or

''(B) affecting the types of health professionals, without application of this subsection, otherwise eligible for assistance, including a loan repayment or scholarship, pursuant to the application of this section.''.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Texas (Mr. BURGESS) and the gentlewoman from Illinois (Ms. SCHAKOWSKY) each will control 20 minutes.

The Chair recognizes the gentleman from Texas.

GENERAL LEAVE

Mr. BURGESS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks and insert extraneous materials in the RECORD on the bill.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?